Financial Assistance Program
Application Instructions

All applicants must provide proof of household income (*for all household members*) by including the documentation listed below with the application. In order to process a financial assistance application through to completion (i.e., rendering a determination), the application and all associated documents must be completed and submitted in their entirety.

Required Documentation (In addition to Application):

- If Employed:
  - Two most recent paycheck stubs (patient and spouse/partner).
  - Two most recent monthly bank statements (all accounts; all pages).
  - Tax return from previous year.
  - Proof of Care Credit approval or denial.

- If Self-Employed:
  - Two most recent monthly bank statements from both personal and business checking/savings accounts (all accounts; all pages).
  - Tax return from previous year.
  - Proof of Care Credit approval or denial.

- If Unemployed:
  - Unemployment award letter (if you receive unemployment compensation benefits).
  - Two most recent monthly bank statements (all accounts; all pages).
  - Tax return from previous year (if recently unemployed).
  - Notarized Letter of Need stating hardship circumstances and how the patient is being supported.
  - Proof of Care Credit approval or denial.

- If Retired:
  - SSN letter and/or Social Security Benefits letter.
  - Two most recent monthly bank statements (all accounts; all pages).
  - Tax return from previous year (if recently retired).
  - Proof of Care Credit approval or denial.

Options to submit Application/Document Package:

- **If you would like to submit your complete package electronically (Email):**
  - Email complete package to: FinancialHardship@advancedurology.com
    - We encourage submissions to be sent securely through encryption.

- **If you would like to submit your completed package In Person/Walk-In:**
  - Bring the complete package to any Advanced location and hand it to a Front Desk Coordinator or Financial Counselor.

- **If you would like to submit your completed package via Mail**:

- Mail complete package to:

  Advanced Urology
  ATTN: Business Office
  1551 Janmar Road
  Snellville, GA 30078

- Once your package is received, we will notify you via phone confirming receipt of package.
  - *If you do not receive a notification phone call from us regarding receipt of your package within ten business days, please contact the Billing Office for assistance with other options to avoid further delays.*

Please allow 2-3 weeks to receive a response regarding the determination of your Financial Assistance application. Once assessment is complete and a determination has been made, a letter will be sent to you via email on file.

Financial Assistance Application

APPLICANT INFORMATION ***ALL FIELDS MUST BE COMPLETED**

Patient Full Name: _____ Date of Birth: _____

Street Address: _____
City: _____ State: _____ Zip: _____ Phone Number:_____

Employer: _____ Years Employed: _____

Number of Household Members and Dependents *(include yourself):* _____

Household Members & Dependents by Legal Name

Name (Last, First, MI)	DOB	Age	Relation	Occupation

Patient's Income Information:

Salary: $_____

Is this amount: □ Hourly □ Monthly □ Yearly

Does you work: □ Full Time □ Part Time

Unemployment: $_____

Social Security or Disability: $_____

AFDC: $_____Child Support: $_____

Savings Account: $_____

Spouse/Household Member's Income Information:

Salary: $_____

Is this amount: □ Hourly □ Monthly □ Yearly

Does he/she work: □ Full Time □ Part Time

Unemployment: $_____

Social Security or Disability: $_____

AFDC: $_____Child Support: $_____

Savings Account: $_____

Monthly Expenses:

Rent or Mortgage (Primary and Secondary) $_____

Utilities (Electric, Gas, Water) $_____

Outstanding Medical Bills (Non-Advanced) $_____

Childcare/Adult Care $_____

Please name your primary Advanced Urology Provider(s): _____

Have you recently been approved for Financial Assistance with another provider's office or hospital? If so, please list name: _____

Other Coverage Questions:

Do you have health insurance?	□ Yes □ No
Are you being treated for injuries covered by third party liability, such as Workers Compensation?	□ Yes □ No
Do you have Medicaid?	□ Yes □ No
Have you applied for Medicaid?	□ Yes □ No

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that if any information I have given proves to be untrue, Advanced reserves the right to re-evaluate my financial status and take whatever action becomes appropriate:

Patient Name (PRINT) : _____

Patient Signature : _____ Date : _____

Documentation to support your application is required in order to process the application. At any time during the application process, Advanced may request additional documentation to assist in the determination of your eligibility for Financial Assistance. Failure to provide this information could result in your application being denied or suspended. Please ensure all required documents outlined in the instructions are submitted with this form.

Should your financial situation change, Advanced may request a new application. A determination of eligibility for financial assistance will be effective for a maximum of 12 months and will need to be reassessed thereafter. Any misrepresentation of the above information may result in the retroactive denial or reduction of financial assistance and the patient/guarantor being held liable. In addition, Advanced reserves the right to evaluate a patient's eligibility under the Advanced Financial Assistance Policy yearly and to adjust the patient's account as necessary.